18-P-98265

Staff Summary Series

No. 85-16

Trends in Pediatrician Participation in State Medicaid Programs

by Benson L. Dutton,
Office of Research

Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

No. 85-16

Trends in Pediatrician Participation in State Medicaid Programs

by Benson L. Dutton,
Office of Research

July 1985

HCFA Grant 18-P-98265/5

American Academy of Pediatrics
Department of Research

Research Objectives

The period 1978 through 1983 saw the passage of important federal Medicaid legislation, the Omnibus Budget Reconciliation Act of 1981 (OBRA) and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The legislation sought to lower eligibility for Aid to Families with Dependent Children (AFDC) and to limit federal financial participation in Medicaid, while providing greater discretion to the states in setting their Medicaid policies. The legislation, along with recession and unemployment, put state budgets under great pressure and forced many states to look for new ways to contain Medicaid expenditures.

This study examines changes that occurred in 13 states in conjunction with the implementation of ORA and TEFRA. The states are California, Colorado, Georgia, Indiana, Iowa, Maryland, Massachusetts, Nebraska, New York, Oklahoma, Pennsylvania, Tennessee, and Texas. The specific objectives are as follows:

- Describe the changes in Medicaid occurring in 13 states as a result of federal and state legislation and regulation during the period 1978 through 1983;
- Describe the changes occurring in pediatrician participation in 13 state Medicaid programs during the period 1978 through 1983;
- Examine changes in Medicaid participation and their associations with changes in Medicaid policy on a state by state basis, drawing policy relevant conclusions from these observations;
- Examine cross-sectional and longitudinal multivariate models of pediatrician participation in state Medicaid programs, with particular attention to the role of state Medicaid policies in influencing participation.

Methods

Data for this study are drawn primarily from physician surveys conducted in 13 states in 1978 and 1983. The states were selected in 1978 on the basis of their widely differing Medicaid policies. In each survey, approximately 800 office-based pediatricians were questioned concerning their Medicaid participation and other aspects of their medical practice. The pediatricians surveyed in 1983 included the panel of 814 pediatricians surveyed in 1978. A supplementary sample of pediatricians entering practice since 1978 was also included in the 1983 survey in order to ensure a sample representative of the 1983 age distribution of pediatricians. Data were also collected from a variety of secondary sources.

Findings

Implementation of OBRA and TEFRA in 13 States

A state-by-state analysis indicates that the 13 study states made unique responses to situations faced with OBRA and TEFRA. The states' politicial and economic realities led to highly individualized adaptations to conditions prevailing during this period. The following common themes emerge:

- Most of the 13 states avoided making deep cuts in Medicaid eligibility during the 1978 to 1983 period. All made the mandated OBRA cuts in AFDC

eligibility but, even with the next flexibility in Medicaid coverage granted by OBRA, few initiated eligibility cuts beyond those mandated.

- Very few states deleted categories of eligibles entirely and often those same categories were subsequently reinstated.

- Few states cut their covered services and, in fact, 7 of the 13 states added services.

- In many states we see innovative responses designed to gain control of rising program costs--particularly through expanded use of new reimbursement incentives.

- Changes also occurred in the management of state Medicaid programs, particularly in efforts to reduce eligibility errors, to control fraud and abuse, and to recover payments from other third parties sharing in the liability for a Medicaid eligible's medical costs.

- A few states substantially reduced reimbursement of Medicaid providers during this period. However, on the whole, the study states showed a preference for cutting and/or restructuring Medicaid reimbursement over major cuts in program eligibility or services.

The state-by-state analysis indicates that in coming years states will rely increasingly on cost containment through manipulating reimbursement incentives. This strategy has the potential to expand access by more efficiently deploying state Medicaid resources. However, this strategy may have unintended costs as well. In many states, recent reimbursement cuts have resulted in a decline in primary care providers' willingness to make office-based services available to Medicaid-eligible children. To the extent that these children continue to receive Medicaid services, it is likely to be in unnecessarily expensive sites of medical care such as hospital emergency rooms and outpatient clinics.

Changes in Participation in Medicaid: Descriptive Statistics

Pediatrician participation in Medicaid has been relatively stable between 1978 and 1983. Although there were many changes in state Medicaid policies, these were generally not significant enough to bring about major shifts in pediatricians' involvement with the program. Some downward trends are evident, particularly in the growing numbers of pediatricians limiting their Medicaid participation. However, with the exception of a few states, participation remained largely unchanged. Some findings are highlighted below.

The proportion of pediatricians participating in Medicaid changed only slightly, from 85 percent, a difference which is significant at the p .10 level. Declines in Medicaid participation varied by state with Pennsylvania showing a decline in participation which was statistically significant.

Among physicians who participated in Medicaid, the average percent of patient load covered by Medicaid fell only slightly from 15.7 percent in 1978 to 14.7 percent in 1983. Although the states vary widely in the average extent of participation among pediatricians, in none of the states were there significant declines in this measure between 1978 and 1983.

There were notable increases in the proportion of physicians who, while accepting all new non-Medicaid patients, indicate that they are limiting their acceptance of Medicaid patients. The proportion who are such "limited participants" increased from 26 percent in 1978 to 35 percent in 1983, a difference significant at the p .01 level. Once again, interstate variation is notable; California, Georgia, Nebraska, and Oklahoma showed significant increases in limited Medicaid participation between 1978 and 1983.

Nonparticipation

Although most pediatricians are participating in Medicaid, there is some reason to be concerned about observed declines between 1978 and 1983, especially in particular states. The 1983 multivariate analysis indicates that nonparticipants are older, less likely to be board-certified, and less liberal in their attitudes about the role of government in ensuring the poor's access to health care. In addition, they tend to practice in areas with more physicians.

In general, nonparticipants are found to be practicing in states with lower Medicaid reimbursement (relative to the physicians' fees), and in states with relatively less generous Medicaid policies, as measured by the Revised Medicaid Program Index (RMPI). The analysis suggests that raising reimbursement and expanding the generosity of state programs would foster a greater degree of participation among pediatricians.

There was a signficant decline in participation in the panel between 1978 and 1983. Such changes in participation in status, if they continued indefinitely, would result in 30 percent of the panel being nonparticipants. This is almost twice the amount of nonparticipation that was evident in the panel in 1978 and 86 percent of the panel pediatricians were found to be participants the changes in participation status are not distributed evenly across the states; Pennsylvania, California, and Colorado each had large net decreases in participation in the panel during this period.

Extent of Participation

Medicaid policies continue to influence extent of Medicaid participation. Positive economic incentives such as relatively higher reimbursement are associated with greater participation, as are the positive professional incentives represented by relatively higher RMPI scores. While significant in both years, the strength of the relationship between policies and participation has diminished in 1983.

The relationship between service area charateristics and participation, by comparison, is stronger in 1983 than in 1978. As would be predicted, physicians practicing in areas with relatively more Medicaid-eligibles are like to have relatively more Medicaid patients. However, where the physician supply is the greatest (and in particular, in metropolitan areas) pediatricians tend to have relatively fewer Medicaid patients. This finding, although not predicted by the theoretical framework, has been consistent in the literature for several years and requires further research.

The panel analysis provides additional insight into extent of Medicaid participation among pediatricians. For example, that 43 percent of the 412 panel members participating in both 1978 and 1983 decreased their Medicaid participation, on

average from 19.4 to 11.2 percent. The largest decreases were observed in California and Oklahoma.

In addition, the panel analysis points to changes in several factors between 1978 and 1983 which were associated with changes in participation. Pediatricians least likely to have decreased their Medicaid participation whose practice costs increased least during this period. Declining economic conditions (such as declining per capita income and increasing Medicaid population in the area of the medical practice) were also associated with being least likely to have decreased participation. Finally, pediatricians practicing in states where professional incentives improved, as measured by increased in the Revised Medicaid Program Index, were also least likely to have decreased their participation in the program. The findings of the panel analysis emphasize that changes in participation between 1978 and 1983 were a function of changes in demand from the Medicaid-eligible population, as well as changing economic and professional incentives created by state Medicaid policies.

Full and Limited Medicaid Participation

Limited Medicaid participation became somewhat more widespread among pediatricians between 1978 and 1983, changing in varying amounts among the states in our sample. These trends are of particular concern because of their implications for the access of low income children to pediatric care.

The 1983 replication of our 1978 model suggests that full Medicaid participation is largely a function of economic incentives facing the pediatrician. Foreign medical graduates, those with low practice overhead costs, and those in nonmetropolitan areas are all more likely to be full participants in 1983. And, in addition, those receiving a relatively higher Medicaid reimbursement relative to their usual fees are also more likely to be full participants in 1983.

The panel analysis provides additional insight into changes in full and limited participation made by pediatricians between 1978 and 1983. Physicians who had been full participants in 1978 and became limited participants in 1983 appear to be responding to the following specific changes: they were most likely to have had increases in practice overhead costs (making Medicaid participation less financially viable), to have moved into a metropolitan area (where limited participation is more prevalent), or to have had a decreased in the level of their Medicaid reimbursement (also making Medicaid participation less financially viable). These findings reinforce those of the replication: becoming a limited participant between 1978 and 1983 was a response to economic constraints which might, to some degree, be mitigated is more positive economic incentives were created by Medicaid policies.

Other Conclusions

Medicaid is in a dynamic policy environment and policy changes have important implications for both access and program costs. Future developments at the federal and state levels will, inevitably, affect physicians participating in the program. It is, therefore, important that Medicaid policymakers and administrators continue to monitor physician participation in Medicaid.

Recent Medicaid policies do not appear to have brought about dramatic declines in participation, although a few states have notable participation problems and the rise in limited participation is an unwelcome trend. However, despite the relative stability in participation, future policies altering Medicaid reimbursement will even more directly affect physicians than have Medicaid policy changes of the recent past. For this reason it is important to continue to monitor participation trends. It is also important that states avoid unduly adverse policies surrounding physicians' participation in Medicaid. If office-based physician participation in Medicaid can be fostered, children will neither have to use relatively more expensive sites of care (such as hospital outpatient departments and emergency rooms), nor still worse, forego needed medical care.

This research also demonstrates the usefulness of multiple levels of analysis in studying federal-state programs such as Medicaid. Two units of analysis are employed: the individual physician and the state. This method of analysis recognizes the value of explanation occurring at both levels. When using the individual as the unit of analysis, one is able to provide a rigorous test of multivariate models of physician behavior. However, such analyses are of limited usefulness in developing state-specific policy recommendations for fostering Medicaid participation. Since Medicaid is a state program, and states retain discretion in policy decisions, it is also necessary to include quantitative and qualitative empirical work using the state as the unit of analysis. This methodological strategy recognizes that the interstate variation in Medicaid limits the ability to generalize from multivariate analyses of the behavior of physicians (in multiple states) to physicians in any particular state. Because of Medicaid's federal-state structure, the study of Medicaid program outcomes requires a multi-level approach in order to be most useful.

The statements and data contained in this internal working paper are solely those of the authors and do not express any official opinion of or endorsement by the Health Care Financing Administration.

Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
6325 Security Blvd.
Baltimore, MD 21207

CMS LIBRARY
3 8095 00014056 2